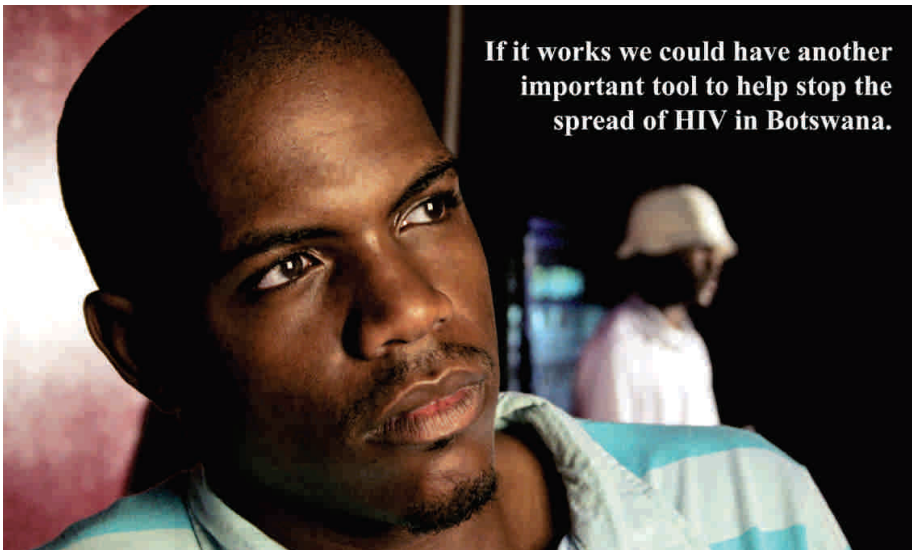
BOTUSA NEWS

July 2007

A United States - Botswana Partnership

Volume 2
Issue 2

Clinical Trial Launched With Hopes of Discovering New Prevention Method



GABORONE - With an estimated 270,000 people currently living with HIV/AIDS, Botswana is in desperate need of new and effective ways to prevent the spread of HIV. Researchers at BOTUSA are hoping to answer that call.

On May 4th, BOTUSA launched a new landmark study to determine whether taking a daily antiretroviral pill can actually prevent HIV infection among adults at risk. The concept, called pre-exposure prophylaxis, would be similar to taking an anti-malarial pill before traveling to a malaria-infected area. The TDF2 trial was launched during a breakfast ceremony in Gaborone, opened by the Botswana Minister of Health, with a goal of recruiting 1,200 young Batswana adults between ages 18-29 who are not infected with HIV.

In the first two months following the launch and new recruitment advertisements, the BOTUSA team screened more than 500 people as potential participants.

"The response is tremendous but we still need more volunteers. We received many calls from people who wanted to know more about the study," says Dr. Poloko Kebaabetswe, a co-principal investigator of the study.

Minister of Health, the Hon. Professor Sheila Tlou, assured those at the launch that the Government of Botswana was a primary partner in the trial who would be looking after the interests of all participants.

"Our Ministry of Health has reviewed and approved the trial and will monitor the well-being of the volunteers who have agreed to participate in the clinical study," she said.

continued to page 8

Interview with Nontombi Gungqisa, a TDF2 trial participant (page 9)

A look inside:

ARVs Rolled Out to Remote Residents

BOKSPITS – Sofia Busang blushes when she recalls the time she won a beauty contest in this tiny village at the southernmost tip of Botswana, and men would call out "Hey there, Miss Tribal!" when she passed.

Things changed when Sophia became sick with HIV/AIDS, a disease that took away her health and confidence. But more recently, with the help of life-saving ARV drugs, Sophia has won back her beauty pageant poise.

"I used to walk like this," she says, demonstrating her illness by crouching low, holding her stomach and moaning. Then, with a wide and toothy grin, she stands upright. "Now (with ARVs), I am like this again," she says, taking big steps with her head held high.

continued to page 6

Dr. Philip Mwala, of the PEPFAR Master Trainer Program, stands atop a dune in the Kgalagadi District, one of the first to roll out ARVs to remote residents.

President Bush Announces Five-Year, $30 Billion HIV/AIDS Plan

President George W. Bush holds Baron Mosima Loyiso Tantoh in the Rose Garden of the White House Wednesday, May 30, 2007, after delivering a statement on PEPFAR. White House photo by Eric Draper

WASHINGTON, D.C. -- U.S. President George Bush announced May 30 that he would work with Congress to double the U.S. commitment to fight HIV/AIDS around the world to $30 billion and reauthorize the legislation that established the President's Emergency Plan for AIDS Relief (PEPFAR). If Congress meets the president's budget request for fiscal year 2008, and with the new $30 billion proposal, the American people will have committed $48.3 billion over 10 years to fight HIV/AIDS. The U.S. contribution is already the largest international health initiative dedicated to a specific disease.

PEPFAR is "a promising start, yet without further action, the legislation that funded this emergency plan is set to expire in 2008," Bush said during a press briefing. "I ask Congress to demonstrate America's continuing commitment to fighting the scourge of HIV/AIDS by reauthorizing this legislation now."

The added $15 billion, he said, "will be spent wisely through the establishment of partnership compacts with host nations. These compacts would ensure that U.S. funds support programs that have the greatest possible impact and are sustainable for the future."

If the plan is approved, the United States will work with governments, the private sector, and faith- and community-based organizations worldwide, Bush said, to support treatment for nearly 2.5 million people, to prevent more than 12 million new infections, and to support care for 12 million people, including more than 5 million orphans and vulnerable children.

The president also announced that through March 31 -- after three years of PEPFAR implementation -- the United States has supported treatment for 1.1 million people in the 15 focus countries, including more than 1 million in Africa. The focus countries are Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia.

2007 HIV/AIDS Implementers Meeting Held in Rwanda

KIGALI, Rwanda – About 2,000 delegates from around the world gathered here for the 2007 HIV/AIDS Implementers Meeting in June to look at how governments, businesses, the health care sector and others can collaborate in the fight against the epidemic.

The conference from June 16-19 was sponsored by the Government of Rwanda, and co-sponsored by President Bush's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Secretariat of the Joint United Nations Programme on HIV/AIDS, the United Nations Children's Fund, the World Bank and the World Health Organization.

The theme of this year's conference, "Scaling Up Through Partnerships," recognized the rapid expansion of HIV/AIDS programs worldwide. Dr. Thomas Kenyon, former BOTUSA Director and now principal deputy U.S. Global AIDS Coordinator, said the theme was meant to acknowledge that while the U.S. government is leading a global response to HIV/AIDS through bi-lateral partnerships, "we can't do it alone."

During many presentations various experts stressed the need to make HIV and AIDS programs and services relevant to the people they serve and to involve local communities in the design and implementation of those programs. The Global Network of People Living with AIDS served as the official advisory group, ensuring that people living with HIV/AIDS were represented as expert implementers. The Botswana Network of People Living with AIDS (BONEPWA) was also represented at the highest levels.

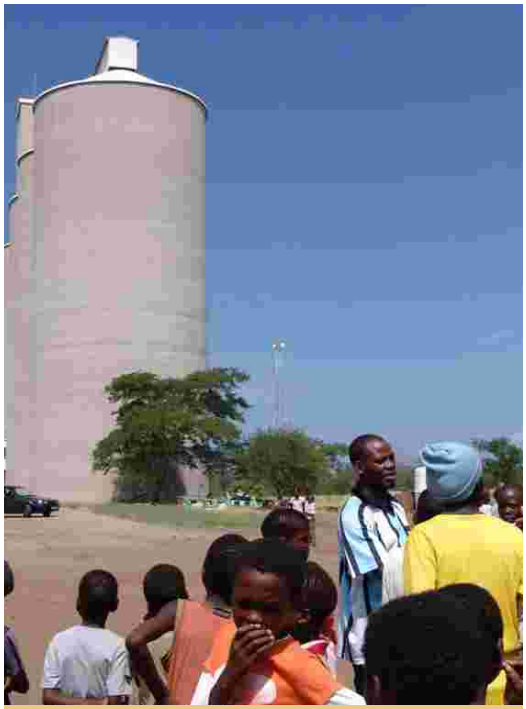
Four BOTUSA delegates presented papers, including Administrative Consultant Reuben Haylett, who presented a poster on "Botswana's National AIDS Spending Assessment Methodology"; Mary Grace Alwano, VCT section leader, presented a paper entitled "Opportunities for Growth and Expansion of Prevention with Positives Efforts in Botswana"; Dr. William Jimbo, section leader of PMTCT, presented "National Implementation of Early Infant Diagnosis of HIV Using DNA PCR on Dried Blood Spots (DBS)"; and Monica Smith, section leader of Development and Capacity Building, presented "Caring for Health Workers: Developing a National Strategy for Botswana."

BOTUSA delegates were accompanied by participants from the Botswana government, NGO sector and other partner HIV/AIDS implementing organizations

ZEBRAS4LIFE & TEST4LIFE

Onalethata Tshekiso, a striker for the Zebras, speaks about the importance of abstinence and "saving yourself" for the right person during an event in Pandamatenga.

Khumo "Shoes" Motlhabane interacts with youth in Pandamatenga.



Motlhabane in Panda after making an example of himself by testing for HIV at a nearby grain storage shed where Tebelopele had set up tables. They saw more than 60 clients that day, more than usually test at the local clinic over a two month period.

Ambassador Katherine Canavan speaking in Kachikau

A woman tries her luck against goalie Kagiso Tshelametse during a raffle prize activity in Nkange earlier this year.

More than 30 villages have been visited by Zebras football players and over 2000 people have tested for HIV since the pilot roll-out of the Zebras4Life campaign in December. U.S. Ambassador Katherine Canavan accompanied Zebras players to a special event in Pandamatenga and Kachikau on April 18-19, hosted a lunch for stakeholders on June 5 and handed over a $75,000 grant (P450,000 BWP) to Tebelopele Voluntary Counseling and Testing Centers on July 19 to aid in the behavior change campaign. The program, sponsored by PEPFAR through the Ambassador's Initiative, is a combined effort from Tebelopele, the Department of Sports and Recreation, the Botswana Football Association, NACA, the U.S. Mission and the Zebras national team.

Female Sex Workers Reveal Risks and Motivations

Anjali Sharma, lead author of the assessment on female sex workers, speaks at a launch ceremony in Francistown.

GABORONE – They sell sex for money or other goods. It's a risky practice – and illegal in Botswana – but it's a reality that female sex workers are still out there, and so are the clients who keep them in business.

Not much is understood about sex workers in Botswana; what risks they take and what motivates them. But a recently released assessment by the International Training and Education Center on HIV (I-TECH) and Matshelo Community Development Association, with support from BOTUSA and PEPFAR, is one of the first to take a comprehensive look at how the world's oldest profession is practiced here.

"I was never interested in this job and never thought I can do it," says one woman in the assessment, explaining her motivation for taking up sex work. "A man came up to me and offered to have sex and give me something. I thought life is good. I was given P600."

The authors of the assessment, which was released during official launches in Francistown and Gaborone in July, sought specifically to understand the risks of HIV infection and transmission, as well as access to prevention and treatment services among female sex workers (or FSWs) and their clients, and suitable interventions to reduce HIV/AIDS transmission in both groups.

One of the most significant findings of the assessment was that few organizations target sex workers for HIV/AIDS prevention interventions, yet FSWs represent a high risk group for HIV infection.

The assessment was conducted in Ghanzi, Gaborone, Selebi-Phikwe, Francistown, Letlhakane and Kasane in 2006. Researchers found that sex work existed in all 6 sites.

Anjali Sharma, a researcher with I-TECH and author of the paper entitled "HIV Needs Assessment of Female Sex Workers in Major Towns, Mining Towns, and Along Major Roads in Botswana," said all participants gave their verbal, informed consent to the interviews and discussions.

"It was not difficult to get FSW or men to talk to us and yes, they were frank," Sharma said. "It was more the NGOs (non-government organizations) and HCPs (health care providers) who were guarded – maybe because the illegality of sex work plays more on their minds."

Motivation for Sex Work

Some common threads ran through interviews with the women, Sharma said, including motivations for entry into sex work. Gender roles, poor education, limited work opportunities and low wages also created the path to sex work for women in Botswana. Participants commonly attributed entry into sex work as a failure of male partners to provide for them adequately and lack of female earning power.

> "I was never interested in this job and never thought I can do it. A man came up to me and offered to have sex and give me something. I thought life is good."
>
> -quote from the assessment

As for the motivation of male clients, several believed that their manliness "was determined by the number of women" with whom they were seen. One man explained that: "In culture past, to realize that this is a man, he had a number of wives. A rich man had seven wives. It still exists today. To recognize that this is a dangerous guy, he must have all of these women around him and we should be able to see that he can take anyone."

Alternative work was not always possible for the FSWs. All of the women but one said that they did not do well in school. About a third of the women interviewed had income-producing work in addition to sex work such as, nanny/maid, hawking vegetables, sales girl, managing a car wash, security guard, hairdressing, and musician; but these jobs did not give the women an income that was adequate to buy the basic necessities.

"It's not easy in jobs," explained one woman. "I was working in a shop. At month-end the owner accused us of stealing and we each got 30-50BWP. Can you imagine working everyday and getting 50BWP at month end? In this job (sex work), I can get 50BWP in one day!"

Women reported earning an average of P700 per month in sex work. Many of these women supported the welfare and survival of their entire family as mothers, daughters, sisters, nieces and granddaughters. Most said they did not enjoy sex with clients; it was motivated by money, not desire.

Condom Negotiation, Health Care and Support

Both men and women said the use of condoms depended on client agreement, on the price that was negotiated and individual ability to insist on condom use. Of the 24 women with regular customers, 12 always used condoms, nine sometimes and three never used them. About half of the 30 women in the assessment reported always using condoms with casual customers and the other half reported intermittent use.

"The men are strangers. They can kill and throw you in the bush. And no-one will even know what happened. He does not want to use condoms just to enjoy sex. For 250BWP spreading AIDS to me. But if he offers, 500BWP I will do it," said one woman.

The women thought health care in Botswana was equitable but did not target vulnerable or priority populations, such as FSW. Women feared taunts from health care providers if they took many condoms.

continued to page 12

Dangerous Practice of Taking Concurrent Partners Fueling Epidemic

A bull cannot be contained to one kraal?

GABORONE – There's a Setswana proverb, "Monna poo ga a agelwe mosako," that says a bull cannot be contained in a single kraal. Literally, it is taken to mean that men cannot be expected to stick to one sexual partner.

But is that really the case in Botswana?

Results from a paper published earlier this year in the journal *AIDS and Behavior* indicate that nearly one in four Batswana questioned had been in sexually active relationships with more than one partner at the same time, and among men questioned it was one in three. This is a practice called concurrency, a dangerous pattern that can speed up the transmission of HIV through the network of sexual partners caught up in its web.

Public health scientists say concurrent relationships may be one reason why HIV prevalence in Botswana and other southern African countries is so high. Understanding this complex practice, they say, will help inform a more comprehensive response to the epidemic.
The Botswana concurrency data was from the *Makgabaneng Radio Serial Drama Listenership Survey*, a population-based survey conducted in 2003 of people aged 15-49 years from seven of the most populous health districts in Botswana.

Out of the 546 sexually active respondents, 23 percent (nearly one in four) reported ever having a concurrent sexual partnership in the last 12 months. Men and non-religious people were more likely to say they had concurrent partners than women or Christians, respectively, but marital status, education, and area of residence did not point to any differences in reported concurrency.

Concurrency was measured for all the respondents who had sex in the past 12 months before the survey. These respondents were asked about their last three sexual partners in the past 12 months. Interviewers asked, "While sexually active with this person, did you have other sexual partners?" Those who said "yes" were coded as having had a concurrent sexual partnership.

Dr. Marion Carter, a program officer for the Behavior Change Communication (BCC) section at BOTUSA and one of the authors of the paper, explains that concurrency means having more than one -- perhaps two or three -- sexual partnerships at a time, which may overlap for days, months or years. This pattern differs from the "serial monogamy" more common in some parts of the world.

"What's so risky about concurrency, even as compared to other multiple partnerships, is that it basically makes the sexual networks that sustain HIV transmission much tighter," Carter says.

The network puts everyone at risk -- not just those who engage in concurrent relationships themselves but anyone who is roped into the network, including monogamous men and women whose partners engage in concurrent relationships or did so in the past.

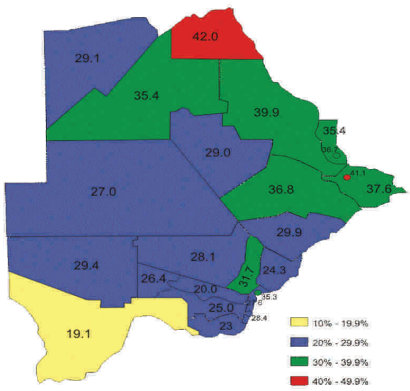
Another reason for the danger, Carter says, is that when someone gets infected with HIV, his viral load rapidly increases for a short time after exposure. So if he has sex with many people during that specific time period -- which someone with concurrent partnerships may typically do -- he is much more likely to transmit the virus.
This pattern of behavior has a powerful historical, social and economic basis, Carter says, but its exact roots are not easy to trace.

"A history of polygamy; a relatively low prevalence of marriage that reflects perhaps more fluid relationships here; some women's use of sexual relationships to obtain lifestyle and livelihood goods and money; some men that get social status by having many lovers -- all of it could be at work here," she says. "It's a very complex behavior. We are keen to understand multiple and concurrent partnerships better, as it's thought to be a major reason that HIV prevalence is high in Botswana."

continued to page 8

HIV Prevalence Data on Pregnant Women Released

This map is from the **2006 Botswana Second Generation HIV/AIDS Surveillance,** a technical report released annually by the Ministry of Health with assistance from BOTUSA and other international partners. This report, released in May 2007, shows the adjusted HIV prevalence in women 15-49 years in Botswana is 32.4%. Chobe district had the highest (42%) where Kgalagadi had the lowest (19.1%) HIV prevalence rate.



Geographic Distribution of HIV Prevalence among pregnant women in Botswana, 2006

continued from page 1

Sofia, an ARV patient in Bokspits, is happy she no longer has to travel to Tsabong every month for her medication

Lenah Metswi, a lay counselor at Middelspits Clinic, says patients have less hesitancy coming forward for ARVs now that they know the service is available close to home

Dr. Mwala helped ready clinics for the rollout of ARVs

Sophia's story is one of many surfacing in far-off places like Bokspits, one of the most remote villages in the Kalahari where a growing number of people are benefiting from the anti-retroviral therapy (ART) program. Patients no longer have to travel hundreds of kilometers along some of Botswana's worst roads to get their medication. The Kgalahadi District is one of the first to successfully roll out treatment to several rural clinics, taking ART out to where people live.

For several years now, Botswana has been at the forefront of the response to the HIV/AIDS pandemic. In 2002, it was one of the first countries in Africa to provide its citizens free AIDS treatment, and now nearly 90 percent (around 82,500) of those estimated to need treatment are receiving it.

The U.S. government is supporting Botswana's treatment efforts with more than $18.5 million in FY2006 and $25.1 million in FY2007 from the President's Emergency Plan for AIDS Relief (PEPFAR). The support goes to purchase drugs, develop treatment guidelines, upgrade security in clinics and support training of health professionals who deliver ART services.

The challenge now for Botswana and its donors is to ensure access to treatment for people living in all corners of the country – from the swamps of the Okavango to the red sands of the Kalahari – leaving no one behind.

Rough Roads

Kgalagadi South District is an enormous, sparsely populated region of southern Botswana sandwiched between the Kgalagadi Transfrontier Park and the South Africa border. In many areas, Afrikaans is the first language spoken and people slip freely across the border to visit relatives or work at nearby farms.

Out of the 950 people currently on ARV treatment in the district, about half of them reside in remote villages (namely Bokspits, Middelspits and Werda) outside of Tsabong, the district headquarters where ARVs are dispensed from the primary hospital. Realizing that many people in these areas are unemployed with little or no income, and no transportation, district officials have pushed for the rollout of treatment to its satellite clinics.

> "Word is getting out that ARVs are now available here, so we have seen people come in big numbers to test for HIV," says Lenah Metswi, a lay counselor at Middelspits Clinic

Bokspits, a dusty village of less than 600 people, may be the best example of how difficult medical access can be for remote residents. Surrounded by red sand dunes, the village is 257 kilometers from Tsabong and the nearest primary hospital. There are no phone lines and often no electricity. Donkey carts are the only mode of transportation for most villagers.

"It is the most inaccessible site out there," says Dr. Philip Mwala, of the PEPFAR BHP Master Trainer Program, who has traveled to clinics around the country to conduct trainings and help with the rollout of ART. "The road to Bokspits is sand and gravel. A drive that should take two hours on a good road ends up taking up to six hours on this road, and that's in a big Land Crusier."

In addition to the poor roads, there is no public transportation. Most people either hitchhike or rely on government vehicles, which are often in disrepair (on a recent weekday, four of the five clinic vehicles for the Bokspits clinic and its surrounding health posts were inoperable). A traveler could wait two to three days for a ride to Tsabong, and when a lift does come it's often an uncomfortable and bumpy ride in the bed of a truck. If the traveler is sick, it can be downright torturous.

"The road is such mathatha (trouble)," explains Sophia, who had traveled it nearly once a month for doctor appointments. "You wait for so long to get a ride, than you are forced to sit in back and bounce without stopping. Even if you want to make water the drivers say 'No stopping!"

The Kgalagadi District began rolling out ART in the village of Middelspits in August 2006, and then to Werda in April of this year. Steadily, patients who enrolled at the primary hospital in Tsabong will be transferred to one of these clinics. With a mobile caravan, the doctors in charge at the two clinics can then take treatment to Bokspits and other places at least once a month.

Nurses and lay counselors at the clinics and surrounding health posts say the rollout has already made an impact on their communities. "Word is getting out that ARVs are now available here, so we have seen people come in big numbers to test for HIV," says Lenah

continued to page 7

Metswi, a lay counselor at Middelspits Clinic. "I think there is less hesitancy now knowing that they can get this service at home without having to travel so far."

The Rollout

Dr. Mutamba Yamutumba has worked as the only doctor in Middelspits since November 2005. Originally from Kinsasha, the capital of the Democratic Republic of the Congo (DRC) with 4.6 million people, he says moving to a village of less than 2,000 was a "painful" experience.

With no phone lines, no local cell phone network and not even a copy machine, the clinic hardly seemed prepared for an increase in clients or the rollout of ARVs. But with construction of a new road and an increase in people testing for HIV, Yamutumba knew the need would be great.

"Without proper communication, we were unsure whether we would be able to start the rollout here. But the DHT (district health team) was persistent and we just got it started," Yamutumba said. More than 100 new patients have registered at Middelspits since last August, and several are being "offloaded" or transferred from Tsabong every week.

The transition hasn't been easy for everyone. The DHT pharmacy technician in Tsabong has to travel to Middelspits and Wera every week, as well as Bokspits and other sites once a month to dispense drugs. It's an exhausting schedule for one person with a lot of responsibility.

"It's tiresome, there is much to be done and the rest of my work is suffering," says Spiwe Gwenukwenu, the pharmacy technician. "But it's worth it. Patients are really benefiting from the drugs."

Part of the success and speed of the rollout is due to Dr. Mwala and his team at the Master Trainer Program, a PEPFAR-sponsored initiative supporting the government's ART program. Last year, more than 380 doctors, nurses and pharmacists received on-going training and 570 lay counselors and family welfare educators (FWEs) were mentored by the staff of the Master Trainer Program.

Dr. Mwala and his team do assessments of ARV sites, give lectures, advice and suggestions on enrollment procedures, adherence counseling and data management, as well as provide hands-on support with difficult patient cases. The Master Trainer program helped upgrade 10 satellite clinics last year.

Challenges

Kgalagadi District clinics are still facing a number of challenges with the rollout of ART, including delays in receiving laboratory results from Tsabong and communication in general between the Matron's office and the clinics. If Matron Eselinah Dube had a wish, she says, it would be to erect telephone lines to Middelspits.

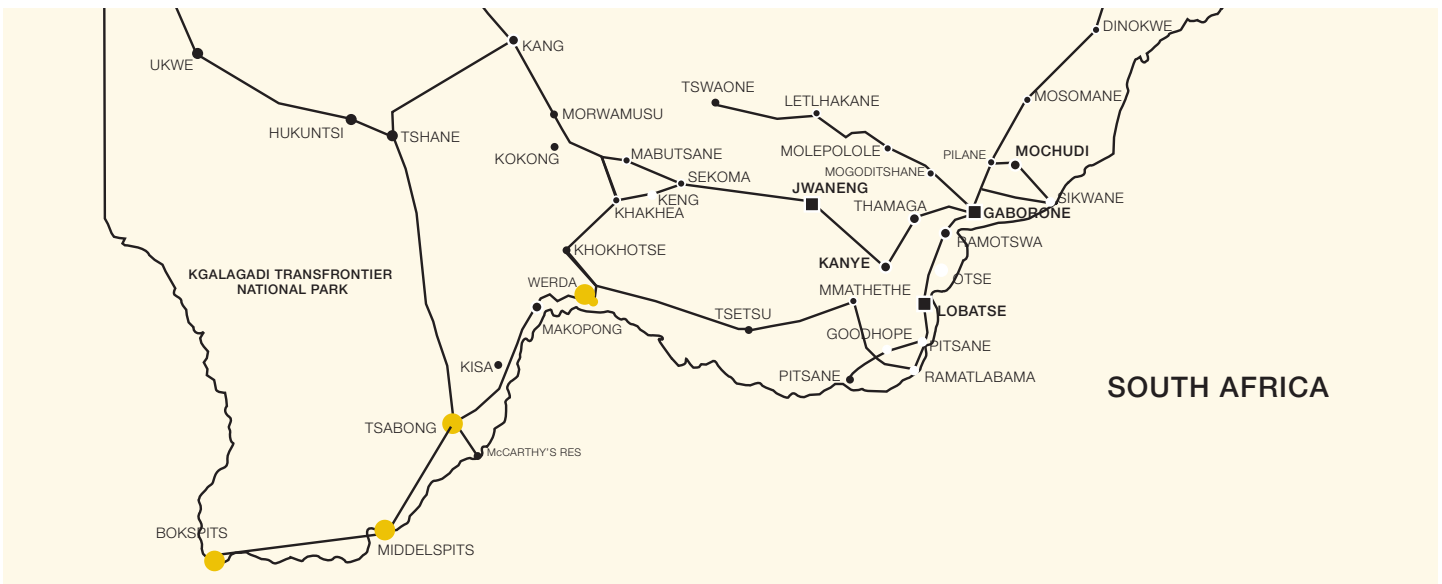
But according to the lay counselors at the grassroots level, the biggest challenges remain with the clients. Alcoholism, language barriers, illiteracy and migration to South Africa make follow-ups with patients difficult.

"I do home visits and it's during these visits that the most education is done," says Hanna, a counselor at the Vaalhoek Health Post a few kilometers from the Bokspits Clinic where she was born 33 years ago. "I can speak to people in their first language (Afrikaans), which is good because sometimes the doctors will get it wrong if they are talking in English."

Dr. Mwala attributes the successes of the ART rollout to the motivated workers, especially people like Hanna who support the clinics and health posts at the grassroots level. "They're level of commitment and record keeping is remarkable," Mwala says. "Without them this couldn't have happened."

Nurse Peggy Thumpe dispenses ARVs at the Middlespits Clinic

Map of Southern Botswana



continued from page 1

"We remain hopeful, as a country reeling from the devastating effects of HIV and AIDS, that if this new prevention method is shown to be effective and safe, we may be able to slow down the epidemic significantly while we and the rest of the world wait for an effective vaccine or cure to be developed," Tlou said.

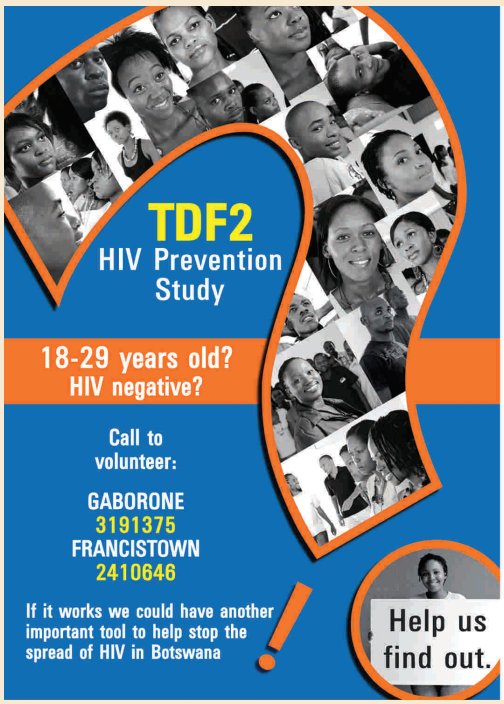
Carefully conducted clinical trials, like the TDF trial in Botswana, are the fastest and safest way to find treatments that work in human beings and ways to improve health, said U.S. Ambassador Katherine Canavan. "Participants in clinical trials can play a more active role in their own health care, gain access to new research treatments before they are widely available, and help others by contributing to medical research," she said.

The director of the Division of HIV/AIDS Prevention at the U.S. Centers for Disease Control and Prevention (CDC), Dr. Robert Janssen, said the need for better prevention options was the biggest motivator for the trial.

"Abstinence works. Being faithful works as well. Condoms work. But we also know that most people are not abstinent, many people are not faithful, and many people do not use condoms the only way they really work, which is correctly and consistently. Or how else would 40 million people become infected with HIV worldwide?" Janssen said.

The trial involves the use of Truvada, a combination of the ARV medicines tenofovir and emtricitabine, which has proven effective in preventing the spread of a virus in animals. It is already widely used for treatment in the United States, Europe, and in some African countries. For treatment of HIV infection, it is taken once a day, doesn't cause many side effects, and is very slow to develop resistance. It has been tested in a few people without HIV infection for a short period of time and has appeared safe.

Dr. Kebaabetswe said that in order to keep the trial objective, half of the participants would be randomly assigned to a placebo



(a sugar pill) while the other half would take the real Truvada. All participants are aware that they may not be taking the real medication and are counseled regularly and provided condoms and testing for all sexually transmitted infections to lower their risk of HIV infection.
Despite all the prevention measures, there is a chance some participants could become HIV infected during the trial. To ensure that infected participants are quickly referred to the best available medical and psychosocial services, they receive free rapid HIV testing at every monthly visit. Participants who become infected will receive confirmatory testing for infection, post-test risk-reduction and support counseling, as well as help enrolling in local HIV care programs, such as antiretroviral treatment.

Tlou said the hope is that the trial results in a prevention method that can be used safely by both men and women, which is especially important to those women who are unable to negotiate condom use.

"It may provide the first possibility of self-protection at a time when the HIV scourge in Botswana and in the rest of sub-Saharan Africa is wearing a woman's face," Tlou said. "The hardest hit section of our population is women in all age groups."

The Botswana trial is running in conjunction with similar pre-exposure prophylaxis, or PrEP, trials in the United States and Thailand. All procedures and plans for the three trials were reviewed and approved by scientific and ethical review committees at CDC as well as by ethic committees established by each host country. Additionally, data on safety, enrollment, and efficacy will be reviewed at standard intervals by an independent data safety and monitoring board (DSMB) for the Botswana trial.

continued from page 5

Perhaps surprisingly, most respondents in the survey (88%) considered fidelity "extremely" important, even those who had reported being in a concurrent partnership. However, 40 percent suspected that one of their recent partners had other partners at the same time, and a third (33.3%) disagreed that most people they care about are faithful.

Carter says these results were heartbreaking. "It sounds like many relationships have elements of mistrust and surely must be fragile. Few people really want that for themselves," she says. "Clearly fidelity is valued by many people, which is a helpful finding for thinking about how we can promote fidelity and partner reduction."

Social scientists would like to address this problem in a comprehensive way, but there are few program models in the world that currently address concurrency. It's the B (Be Faithful) in the ABC approach to prevention, and any response here will be one started practically from scratch.
"We've got to try to help make people more aware of the risks of concurrent and other multiple partnerships and benefits of partner reduction and fidelity," Carter says. "We also must promote community dialogue and find out what communities, families, and couples really want for themselves; and try to provide the skills and services to help them achieve that. What's for sure is that it is not the kind of thing that can change overnight."

Interview with Nontombi Gungqisa, a TDF2 trial participant

GABORONE – Nontombi Gungqisa, a 25-year-old University of Botswana student, is participating as a volunteer with BOTUSA in the TDF2 Trial. An avid believer in "doing your part to help your country," Gungqisa shares what it's like to be a participant in a clinical trial.

1.When did you first learn about the clinical trial and what was your first impression?

The first time I heard about it was in January of 2006 from a friend who works in the field and knows me well, she knows what inspires me and what interests me. She knew that I have always worked in some fashion in HIV/AIDS, and I care about the issue very much. Our President Festus Mogae said we should all take part in doing something about this epidemic, and so I responded in the way I knew I could. I did not have lots of money, but I knew I could volunteer my time in order to benefit myself, my community and my country. So I did.

2.Has your attitude about the trial changed at all since you first enrolled?

Not really my attitude, but there have been several changes in the role of trial participants. At first I think things seemed more discrete, like we were hiding from each other and the public. But we participants said it shouldn't be that way. We are very proud to be a part of this, so things are more transparent now. We have even formed a Participants Advisory Group to discuss any challenges we face as trial participants and to have a more unified voice when addressing issues with the research staff.

3.Do you know people infected or affected by HIV/AIDS and did it play a role in what motivated you to volunteer for the TDF2 trial?

Like I said before, it's just the kind of person I am. I have always been interested and volunteered to work on HIV/AIDS issues. At one time, I thought it was a dreadful and hopeless disease, but after working with people living with AIDS, I came to realize it's something you can live with positively. I became a peer educator at my workplace, and later helped train other peer educators to counsel people on HIV/AIDS issues and condom use. I still help with peer training and orientation of new students at UB.

If there is anything I can do to help further the fight against HIV/AIDS than I will do my best to help. And that's what this TDF2 trial is all about.

4.As a volunteer for the TDF2 trial, how much time do you have to give?

Really, I spend about 30 minutes to an hour each month. You are given free counseling and a check-up with the doctor once a month which takes about 30 minutes. On your first visit, it may take slightly longer because they have to explain, in-depth, the risks and benefits to being a volunteer in the trial. They want to make sure participants fully understand what they are doing.

Since I am on the Participants Advisory Group I can spend maybe another 30 minutes per month in meetings.

5.Are there any drawbacks or worries to being a trial participant?

There have been no real drawbacks or worries. I am doing this with passion because I know it benefits me and my country.

Some people think it will be difficult to take a pill every day. But you can decide what time of the day you are going to take that pill, then you just take it. If you enjoy what you are doing and know why you are doing it, there is nothing difficult about it.

The BOTUSA researchers explained that since this is a trial to find out if Truvada works, some of us might get Truvada and others might get a placebo (a pill that looks and tastes like Truvada but has no medicine in it). Since there is no way to know if you are getting the medicine, you know that you cannot indulge in risky behavior. And participants are likely at lower risk of infection because of the prevention services offered to them.

6.What are the personal benefits to being a trial participant?

It is beneficial to me because I get a free check-up and health advice from a doctor once a month. I know I am a safe and healthy person because of this. During these check-ups they say they will take care of you, and they really do. You get an HIV test, a pregnancy test for women, male and female condoms, and sometimes physical examinations and blood work. You can be told about how to reduce risks in your life and how to watch for other diseases like breast cancer or sexually transmitted diseases. On top of it all, you get transport money to come to your appointment once a month. These days it's expensive to see a private doctor for this kind of care and public health clinics don't really have time for you unless you are already sick.

7.What do your family and friends think about you participating in a clinical trial?

They were not shocked and my family was very supportive. They know I am passionate about such issues, so it was only natural that I would volunteer for this. In fact, it has been educational for all of them to learn through my participation. They saw me as a role model and I have actually convinced several of my friends to also volunteer for the trial.

8.Do you have any advice for others considering participation in the trial?

I would just encourage young people to come forward and take part in this fight against HIV/AIDS. This is not about money, it's just something you can do to add value to your life and to help the country.

Personally, I have faith and hope that someday soon we will beat this virus. If this Truvada does work, than we will have another prevention tool in the fight against HIV/AIDS. That will take us one step closer to our nation's vision of "no new infections by 2016."

SMDP Alumni Share Successes at 2007 Conference

Participants of the 2007 SMDP Alumni Conference

GABORONE – Graduates of the Sustainable Management Development Program (SMDP) had much to say at the 2007 Alumni Conference about the successes of their health programs on HIV/AIDS and TB services around Botswana.

The theme of May 22nd Alumni Conference was "Improving Public Health Management for Sustainable Development Programs – A Healthier Botswana by 2016." Public health managers gathered at the GICC shared knowledge and skills on everything from improved sputum collection to increased couples counseling and testing.

SMDP is a certificate course developed through the collaborative efforts of the Institute of Development Management (IDM), BOTUSA and the U.S. Centers for Disease Control and Prevention (CDC) in Atlanta. Botswana's participation in SMDP began in 2000 and the first group graduated in 2003.

The course targets managers working in public health from the public, private and non-governmental sectors and has two important objectives: 1) Empower public health managers with better leadership, management, and decision-making skills; and 2) Stimulate creativity and innovation among managers to improve the delivery of public health services.

The first presentation at the 2007 Alumni Conference was by Cynthia Caiphus, the TB Coordinator in the Kanye/Moshupa Sub-District. Her team focused on a project to improve sputum collection at 6 months in her district.

Caiphus stated that from July to December 2004, 83 out of 106 TB patients (or 78%) in five clinics did not have sputum collected at six months as per TB treatment protocol. After SMDP training, the team investigated the problem and came up with countermeasures that included educating patients on importance of sputum collection; educating health workers on stock management; and training of health workers on the TB program and the importance of adherence to treatment protocol.

"We began putting more emphasis on customer care. The privacy of patients was emphasized in order to cut down on stigma that kept patients from coming for sputum collection," Caiphus said.

After the count measures put in place, May to August 2005 showed that the percentage of non-collection at 6 months had dropped from 78% to 39%.

In another presentation, Segametsi Segosebe, a Tebelopele manager in Maun, spoke about improving the uptake of couple HIV counseling and testing at the Maun Centre.

In September 2006, just 10% of the 13,088 clients tested for HIV as couples. It was evident that some of the clients that tested as individuals had actually wished to test as couples, Segosebe said, but they did not know much about the availability of Couples HIV Counseling and Testing (CHCT) services.

After counter measures were put in place – including more promotional materials, daily educational talks at the center and outreach targeting couples during weddings at the Kgotla, DC's office and church – numbers of couples testing increased to greater than 15%.

Stamped Card Now Available to Clients of Tebelopele VCT

GABORONE – A new HIV testing service that gives clients the option of receiving a stamped card revealing their status -- either "Negative" or "Positive" -- is now available at the Tebelopele Counseling and Testing Centers.

"It helps clients with the issue of disclosure. Sometimes it's easier to show someone the results on a card," says Innocentia Puso, the southern regional director of Tebelopele.

Prior to January this year, Tebelopele offered only anonymous testing. Under this method there were few ways to do follow-ups with clients and no way to see if they needed further assistance. Clients were told verbally if they were HIV positive or negative, but had no written confirmation when leaving the center.

With the new `Confidential Testing' option, the benefits are numerous. It helps Tebelopele counselors refer and track clients, and it helps clients convince their partners of their status with a stamped "Passport to Life" card.

Innocentia Puso, the southern regional director of Tebelopele, says clients still have the option of either confidential or anonymous testing. But for the most part, the public has accepted confidential as the best option.

continued to page 11

BOTUSA staff news

Dr. Thabisa Sibanda joined BOTUSA on April 29 as a TB medical officer. Sibanda, 35, graduated with a Doctor of Medicine degree from the University of Zimbabwe in 1997. Having been involved in TB from 1999 to 2002 as a District Medical Officer in rural Zimbabwe, he joined the Bulawayo City Council in 2002 as a Clinical Medical Officer.
Sibanda left his native country to work as an AIDS Coordinator for Gaborone City Council from 2003 -2004 before teaching family nurse practitioners at Kanye SDA College of Nursing from 2005 – 2006.

Sibanda is currently reading for a Masters degree in Clinical Trials with the University of London School of Tropical Medicine and Hygiene. He is married and has 5-year old twin daughters. He loves choral music and is an avid supporter of soccer and cricket.

Dr. Lovemore Chirwa has joined the HIV Prevention Research arm of BOTUSA in Francistown as a study physician.

Chirwa, 40, of Zambia, first came to Botswana in July 2001 and helped establish the Infectious Disease Care Clinic (IDCC) at Selebi-Phikwe Government Hospital. He left in November to join BOTUSA.
He attended the University of Zambia and graduated in 1992. Upon completion of his internship at Ndola Central Hospital, Chirwa was employed by the Zambia Consolidated Copper Mine (ZCCM) Hospitals in Mufulira as a Medical Officer. He was in charge of training first-aid to mine employees and was a doctor for Mufulira Wanderers Football Club, noted for producing the legendary 1988 African Footballer of the Year, Kalusha Bwalya. Chirwa is also a member of the Confederation of African Football (CAF) Physicians Committee.

Dr Evans Muhavani Buliva, 41, from Kenya joined HPR-Gaborone as a research medical officer in January 2007. Buliva attended medical school at the University of Nairobi, graduating in 1992. He worked for the Ministry of Health in Kenya at Machakos General Hospital and Kenyatta National Referral Hospital. In 1994, he went to Rwanda to work for the Christian NGO World Vision International. The work involved rehabilitating, equipping and staffing war damaged rural health centers in remote parts of that country. Buliva came to Botswana in 1995 where he has worked for both the Government and private sector, covering primary health care clinics in Gaborone, Sowa Town and in Selebi-Phikwe. He is married with 3 children.

Mpho Mogodi, a Palliative Care Medical Officer in the Global AIDS Program, has left her position after a year at BOTUSA. She will be taking up the De Beers African Health Scholarship Award to pursue a public health fellowship at the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland, USA.

continued from page 11

From January to March this year, Tebelopele tested 32,465 clients nationwide. Out of those, 21,585 (66%) opted for confidential testing. Of those clients who opted for anonymous, many did so because they had forgotten their Omang, Puso said.
There were also more repeat testers in the first three months of 2007 than ever before, says Puso, because many clients wanted to take advantage of the new service and get their cards stamped.
In the coming year, Tebelopele centers expect to offer Post-Test Clubs which would offer prevention for both HIV positive and negative clients.
"There is a lot happening with Tebelopele right now and we have a lot to offer the public. It's time more people came to get tested," Puso says.

Testing centers opened in Mochudi and Molepolole

MOCHUDI – Tebelopele Voluntary Counseling and Testing Center has officially opened two new testing sites this year in Mochudi and Molepolole with plans for three more to open soon.
While VCT previously existed in those villages, the dedication ceremonies signified the growth of Tebelopele with new brick buildings constructed by the U.S. government.
The Mochudi dedication on April 30 was attended by Katherine Canavan, U.S. Ambassador to Botswana; and Rear Adm. Michael Lyden, U.S. European Command security assistance and logistics director.
Molepolole was dedicated on Feb. 28 with help from Canavan and General William F. Hobbins, the U.S. Air Forces Europe commander.
The sites were the eighth and ninth centers out of 12 to be completed in a multi-year, $3 million project, which began in 2001 and is scheduled for completion by the end of this year. The project was made possible with funding from the U.S. European Command's Office of Defense Cooperation Humanitarian Assistance program.
Additional centers will be located at Lobatse, Maun and Francistown. The program was created to provide counseling and testing centers in every major population area in Botswana.
Tebelopele is a nongovernmental organization initially created by the U.S. government and funded by the President's Emergency Plan for AIDS Relief (PEPFAR).

President Bush announced in May his intentions to reauthorize the President's Emergency Plan for AIDS Relief (PEPFAR) and double America's commitment to $30 billion.

BOTUSA Director Dr. Margarett Davis

While it still requires Congressional approval, the announcement bodes well for Botswana and other focus countries that have especially benefited from the President's initiative.

Such an increase speaks volumes about the progress partnerships between the U.S. and other countries have made in the struggle against the HIV/AIDS pandemic. In Botswana, we are already seeing modest declines in HIV prevalence, especially among the youth, and the majority of people who need ARVs (nearly 90 percent) are receiving them.

With the prospect of increased funding comes an added burden of accountability. We must remain diligent in monitoring and evaluating our successes and failures. With this in mind, the U.S. team in Botswana has recently released the FY2006 Annual Report for PEPFAR under the theme, "Going to Scale: The Power of Partnerships."

PEPFAR is implemented by BOTUSA and other U.S. agencies, including the Embassy, the Agency for International Development (USAID), Peace Corps, the Department of Defense and the Office of the U.S. Global AIDS Coordinator. Each plays a role in forming partnerships with government, non-governmental organizations and the private sector to implement programs for combating HIV/AIDS and to ensure efficient use of USG resources.

Highlights from the Annual Report include a breakdown showing how the $54.9 million given to Botswana in FY2006 was prioritized by program areas (i.e. Prevention, Care, Treatment and Capacity Building). For instance, it's interesting to note that out of the $15.2 million going to Prevention, 37% was for programs promoting abstinence and being faithful; 21% was given to Prevention of Mother to Child Transmission; 25% in programs to prevent medical transmission of HIV and 17% for condoms and other forms of prevention. It's also notable that out of the $18.5 million given to Treatment, nearly 60% was spent on purchasing ARV drugs.

The report isn't all about numbers. It also looks at how the support has affected real people and grassroots organizations. A 25-year-old HIV-positive mother in Francistown explains how PMTCT helped prevent her twin boys from being born with HIV; and a Peace Corps volunteer in Makaleng talks about her experiences working for a support group for people living with HIV/AIDS.

The United States supports the changing paradigm for development, rejecting the "donor-recipient" mentality and replacing it with an ethic of true partnership. It means relationships between equals based on mutual respect, understanding and trust, with obligations and responsibilities for each partner. We hope that the Annual Report is a step in the right direction in keeping PEPFAR transparent and a success for Botswana.

continued from page 4

The women thought health promotion on HIV, VCT and social support should reach them as groups through peers.

Service Providers

Very few organizations target sex workers in Botswana. One organisation that does is Matshelo Community Development Association (MCDA), a network organization that teaches women how to reduce the number of clients and negotiate for consistent condom use; but they have had little support from partners due to lack of interpretation of laws on prostitution.

"People fear that helping sex workers is tantamount to illegal activity," Sharma said. Needs of FSWs include negotiating powers and accessing public assistance such as housing, child welfare, job training and education. Also, there is need for a discrete public, or non-governmental, clinic that caters to all these needs for sex workers.

Targeting FSW to reduce harm in sex work is necessary, but the researchers concluded that interventions must also target men.

"Targeted interventions at FSW are relatively easy to implement and have a high impact on STI/HIV prevalence rates in this and the general population," Sharma said. "However, the success of such interventions would depend on the solidarity (agreement on condom use and price) between FSW, their clients (men), health care providers and the police."

BOTUSA is collaboration between the Government of Botswana and the U.S. Centers for Disease Control and Prevention (CDC). We are located at Plot 5348, Ditlhakore Way, Ext. 12; Phone: 3901696, Fax 3973117. Suggestions and comments can be emailed to Doug Johnson (johnsond@bw.cdc.gov) or Sechele Sechele(secheles@bw.cdc.gov).